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Empathy, Perspective-Taking and Social Decentering in the Context of Health Care Professionals, Teams, Organizations, and Intercultural Interactions

Mark V. Redmond
Iowa State University, mredmond@iastate.edu

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Abstract

Whenever we anticipate interacting, interact, or reflect on interactions with other people, we have the option of engaging in social decentering to help us in our planning, understanding, and adapting. We are also affected by the other person's use of social decentering on us. So far in this book the focus has been on interpersonal interactions, specifically those with friends, romantic partners, and spouses. That discussion provides a broad and encompassing understanding of social decentering and relationship-specific social decentering (RSSD) that can be applied to any human interaction. However, some interactions are defined by specific roles and contexts that affect the use, value, appropriateness, and impact of social decentering. For example, psychotherapy is seen as a specific form of interpersonal interaction (Hatcher, 2015), where the roles of the therapist and client guide the interaction. In organizations, managers with strong social decentering abilities are likely to make different adaptations to subordinates who are late to work than they do when their children are late for dinner. The roles that managers play toward subordinates evokes different goals in using social decentering (maintaining a productive workforce) than it does in interacting with their children (teaching responsibility).

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Empathy, Perspective-Taking and Social Decentering in the Context of Health Care Professionals, Teams, Organizations, and Intercultural Interactions

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Note to Readers: The following is the last chapter from a book on social decentering and builds on information contained in other chapters. Consider first reading the short description of the concept provided in the separate download entitled "Empathy, Perspective-Taking and Social Decentering."

Whenever we anticipate interacting, interact, or reflect on interactions with other people, we have the option of engaging in social decentering to help us in our planning, understanding, and adapting. We are also affected by the other person's use of social decentering on us. So far in this book the focus has been on interpersonal interactions, specifically those with friends, romantic partners, and spouses. That discussion provides a broad and encompassing understanding of social decentering and relationship-specific social decentering (RSSD) that can be applied to any human interaction. However, some interactions are defined by specific roles and contexts that affect the use, value, appropriateness, and impact of social decentering. For example, psychotherapy is seen as a specific form of interpersonal interaction (Hatcher, 2015), where the roles of the therapist and client guide the interaction. In organizations, managers with strong social decentering abilities are likely to make different adaptations to subordinates who are late to work than they do when their children are late for dinner. The roles that managers play toward subordinates evokes different goals in using social decentering (maintaining a productive workforce) than it does in interacting with their children (teaching responsibility). In this chapter, I will briefly discuss some of the more common contexts in which other-oriented processes have been applied and studied – health care/counseling, teams/ groups, organizations, and intercultural interactions. Rather than providing an extensive review of the literature on empathy and perspective-taking related to each application, the focus of the discussions will be the major role that social decentering and RSSD play in each context. I have chosen not to include a number of research articles that appear to be examining the roles of empathy or perspective-taking in a given context because of methodological

concerns (see Chapter 2). For example, I have avoided studies that measure empathy using only Davis' measure of empathic concern which by fiat, are focused more on the empathizer's own emotional reactions (feeling sorry or being soft-hearted) than on feeling what the target is feeling.

The largest context into which empathy has been applied is the health care professions such as therapists, counselors, nurses, and physicians. For some health care professionals, empathy is one of the primary tools used to accomplish their goals. Indeed, the essence of Carl Roger's (1951) client-centered therapy is the use of empathy by therapists to help clients reorganize their self and adjust to life. Rogers (1975) observed that "a high degree of empathy in a relationship is possibly *the* most potent and certainly one of the most potent factors in bringing about change and learning" (p. 3). Empathy has been identified and advocated as a significant counseling skill for many years (Benjamin, 1969; Carkhuff, 1969; Gladstein, 1983; Rogers, 1957; Truax and Carkhuff, 1967). Rogers (1975) and Carkhuff (1969) saw counselors using empathy to identify and describe client feelings that the client is scarcely aware of or chosen not to express. In this sense, empathy goes beyond using just what is observed by using one's imagination for input, as reflected in the social decentering model. Rogers felt that counselors shouldn't actually experience the client's feelings; likewise, Katz's (1963) fourth and final stage of empathy in the counseling situation involves "detachment from shared feelings" to increase a counselor's objectivity that might otherwise be clouded by empathy.

The notion of detachment contrasts with the conceptualizations of empathy that involve feeling what the other person feels. Nonetheless, experiencing empathy in the sense of sharing the same feelings as a client/patient could be detrimental to the outcomes of a professional health care interaction. Counselors are likely to burn out quickly if they are constantly experiencing the same emotions as their clients. In this sense, health care professionals are well served by that part of the social decentering process that involves recognizing and perhaps even feeling some of the same emotions as their patients, but ultimately turning to their cognitive process of understanding the emotions and developing strategies to address them.

Variations in conceptualizations have led to contrasting measurement emphasis with some studies focusing on the perception of empathy by clients and patients and other studies focusing on the possession of empathy by the health care professional. As a result, research on empathy and perspective-taking among health care professionals is inundated with conceptual and methodological contradictions. Empathy is defined and measured in such a wide variety of ways it undermines the ability to synthesize and

combine concepts and results. Sometimes the approaches are too simplified and fail to reflect the complexity of being other-centered. The multidimensional nature of social decentering theory and scale should more completely capture what occurs when health care professionals engage in other-centeredness while analyzing and responding to clients and patients' cognitive and affective dispositions.

A variety of studies have found support for a positive impact of being other-centered on the outcomes of a health care interaction. For example, Anderson, Ogles, Patterson, Lambert, and Vermeersch (2009) found that therapists' interpersonal facilitative skills (such as empathy and developing a therapeutic alliance) were associated with better therapy outcomes. For other professions such as nurses and physicians, empathy plays a less obvious but no less important role. For health care givers, the values of being other-orientated through social decentering or empathy include building helpful relationships, gaining information, gaining and sharing insights, and providing support and comfort. Studies on the impact of physician empathy on patients found "improvement in patient satisfaction and adherence, decrease of anxiety and distress, better diagnostic and clinical outcomes, and more patient enablement" (Derksen, Bensing, & Lagro-Janssen, 2013, p. 78). Research has also shown when nurses have strong empathy, they are able to better sense the patient's readiness to talk, create a climate of trust, and understand the patients' responses to health problems (Reynolds & Scott, 2000). Strong empathy in nurses helps patients reach positive health outcomes, reduce physiological distress, improve their self-concept, and reduce their anxiety and depression (Reynolds & Scott, 2000). Unfortunately, Reynolds and Scott (2000) indicate that studies find a substantial lack of empathy among physicians and nurses.

For counseling and therapeutic applications, Rogers (1951) described how other-centeredness applies:

> […] the counselor's function to assume, in so far as he is able, the internal frame of reference of the client, to perceive the world as the client sees it, to perceive the client himself as he is seen by himself, to lay aside all perceptions from the external frame of reference while doing so, and to communicate something of this empathic understanding to the client. (p. 29)

Rogers' description of therapists' other-orientation suggests that their responses are not truly empathic in the sense of the therapist having the same emotional reactions as the client. Rogers emphasized that a therapist should perceive the hates, hopes, and fears of a client but not actually experience those hates, hopes, and fears. Rogers' main concern is the perception of empathy by the clients rather than the therapists

experiencing similar emotional responses to the clients; this lead Rogers (1975) to conclude "clients are better judges of the degree of empathy than are therapists" (p. 6).

In Chapter 2, I discussed the principle that people can engage in social decentering yet not produce any discernable adaptive behaviors. Thus, others' assessment of those individuals' behaviors would lead to the conclusion they have not engaged in social decentering. Of course, in therapy the emphasis has been how the perception of empathy affects a client. This perspective ignores the value of engaging in empathy by therapists even when not observed by the client. The conflicting views of empathy and perspective-taking might be one reason studies often fail to find a correlation between a person's self-report and their partner's observations (see, e.g., Park & Raile, 2010). Social decentering that doesn't produce observable responses (internal responding) still can be valuable to the decenterer, just as social decentering that results in adaptive behaviors (external responding) can be valuable to the recipient. Internal responding includes the development of more complex understanding of others and strategic decision-making (e.g., censorship of certain comments or reactions that are considered detrimental to the client/patient). External responses produce verbal and nonverbal messages that allow clients and patients to feel understood and confirmed. Much of the research and focus on empathy in counseling focuses on producing external empathic responses. Such focus makes sense, since it reflects the primary concern of using empathy to positively affect the client.

External and internal responses are also measured in different ways – self-reports versus observer reports (considered objective). A meta-analysis of empathy training found that training produced a greater impact on objective measures (observational) of empathy than on self-reports, though self-reported empathy did improve (Teding van Berkhout & Malouff, 2016). Often empathy training focuses on modeling behaviors and role-playing which of course is more likely to create change in observable behaviors than in social cognition. Besides training, experience can facilitate improved other-centeredness. Anderson et al. (2009) found that the age of therapists was positively associated with therapy outcomes but that effect appeared primarily due to increases in interpersonal facilitative skills as therapists gained experience (aged).

The following discussion of how social decentering applies to counseling, therapy, and other health care professionals is structured on the dimensions of social decentering presented in Chapters 1 and 2 beginning with what motivates its enactment. The very act of interacting as a health care professional with a client/patient should inherently activate social decentering. Inherent in the role of many care providers is understanding and adapting to the client/patient. While this should happen automatically, some professionals become entrenched in playing out a role divested of sensitivity to others.

Physicians are somewhat notorious for failing to adequately consider the patient's perspective (Spiro, 2009). As a result, medical schools often take steps to improve physician empathy and perspective-taking, particularly since medical students' empathy declines over the first 3 years of medical school (Hojat et al., 2009). I once conducted a communication workshop in a hospital that was open to any staff member. A number of nurses and support staff attended and found the training on becoming more other-centered very helpful, but at the end of the workshop several of them commented on how they wish that the physicians would have attended. They recognized that sensitivity to others, both patients and staff, was a quality doctors often failed to display.

Activation: Activation of social decentering requires motivation to engage in social decentering which means health care professionals need to feel there is something they will gain by expending the time and energy needed to understand the dispositions of their clients, patients, and co-workers. An obvious but underappreciated value of social decentering is that it facilitates achieving job goals. Studies indicate that physicians with stronger empathy make more accurate diagnoses, gain greater patient adherence to treatment, elicit greater patient satisfaction, and are sued less for malpractice (Hojat, 2016) – they more effectively accomplish their medical goals. Believing such values accrue from social decentering can be an impetus to be more client/patient-centered. Unfortunately, the demands on a health care professional's time and energy are often to the detriment of the time and energy needed to develop and engage in social decentering, and even more so, for RSSD. For example, the time physicians have for patients in a clinical setting is often barely enough to learn the patient's current medical needs which leaves little, if any, time to learn the more personal information on which to more substantially ground social decentering and RSSD. Dr. Spiro (2009), an emeritus professor of medicine at Yale University, strongly advocates for physicians to be empathic and wrote:

> Physicians must have the time to listen to their patients. Listening can create empathy – if physicians remain open to be moved by the stories they hear. Empathy has always been and will always be among a physician's most essential tools of practice. (p. 1179)

Ultimately, health care professionals must make the decision to exert a conscientious effort to be client-centered. In presenting his client-centered approach to therapy, Rogers (1951) observed that those who were already motivated and working toward understanding others learned the client-centered techniques more quickly. For Rogers, the right attitude, personality, and philosophical orientation toward respect for others

provided the motivation to be client-centered. He saw students able to achieve empathic understanding if they had the desire to understand other's viewpoints. These same motivations and desires lead many health care professionals to engage social decentering.

Input: Once the decision is made to engage in social decentering, the next step is taking inventory of what information is available on which to base an analysis of the client/patient. The information step of social decentering involves using experience-based information (observation and recall) and imagination-based information (extrapolating from experience-based information).

To best examine the role of information to the health care professional, I am going to describe a typical first time medical patient interaction (based and biased primarily on my own experiences). A patient meets with a nurse or aide who asks what the issue is and/or collects other initial information about the patient's visit. Since the patient doesn't know the nurse, the patient provides limited and specific information. Without a preexisting relationship, the patient might not feel sufficient trust to share more. Before seeing the patient, the physician reviews the information collected by the nurse. Upon meeting the patient, the doctor shares her or his understanding of the situation and asks the patient for any additional information. Again, no real relationship exists, and trust is somewhat limited. The physician then conducts an examination, perhaps sending the patient for further tests. The process ends with the physician engaging in or prescribing some course of action. In extended research interviews with 35 patients who had just met with a doctor, 31 did not fully share their concerns (Barry, Bradley, Britten, Stevenson, & Barber, 2000). The failure to fully share concerns was due to doctors not seeking or attending to the relevant information and from patients worried about the appropriateness of disclosing and wasting the doctors' time. An option for health care providers to gain both trust and more personal patient information is for the provider to self-disclose. This takes advantage of the strategy discussed in earlier chapters for gaining information by using the dyadic effect or reciprocity of self-disclosure. Research has found that self-disclosures by counselors lead to self-disclosure by the clients/patients (Henretty & Levitt, 2009; Henretty, Currier, Berman, & Levitt, 2014).

Throughout the medical visit example, the focus was on gaining information pertinent to the physical condition of the patient. Let's consider how social decentering could enter into this process. The focus on medical history and symptoms limits the kind of information contributing to social decentering. In counseling and medical interactions, the health care professionals draw from their extensive experience-based

catalog of information that relates to what they are told by the client or patient. A client who expresses feelings of depression leads therapists to access the information they have accumulated. Over time, as a relationship is developed between the health care provider and the patient, more information is learned. Unlike interpersonal interactions, professionals almost always record the information they learn from the client and access that information as needed in subsequent visits. While such records insure accurate recall of information, it might restrict the acquisition of more personal information because the focus is on writing notes and recording symptoms that can undermine empathic listening. How health care professionals can improve the acquisition of personal information is discussed later.

Until more is learned about a patient, imagination-based information has a limited role in health care interactions. But creativity and imagination are seen as important qualities for a physician to have (Altschuler, 2016). Imagination allows the physician or therapist to consider experience-based information in creative ways that can provide both insight and understanding. As a relationship develops, the health care provider can use imagination as a way to consider how the patient or client is likely to respond to new information and treatments. Imagining how a given patient is going to react to a diagnosis of terminal cancer allows a physician to consider how to best share the diagnosis and to prepare support resources adapted to that patient. After reviewing theory and research on perspective-taking, Lobchuk (2006) observed that patient caregivers could attain greater empathic accuracy "by imagining how patients perceive their situations and how they feel as a result" (p. 338). Someone does not need to experience cancer to imagine what someone else might be thinking and feeling. Such use of imagination-based information benefits from being grounded in experience-based information where a caregiver uses previous experiences with patients to imagine a particular patient's thoughts and feelings. But in doing this, health care professionals also need to be sensitive to and incorporate in their imaginings how the particular patient differs from previous patients.

The use of social decentering is not limited to health care providers, but also extends to users. Clients and patients also engage in social decentering during these encounters. Patients' previous experiences with health care professionals serve as the foundation for deciding on how to behave and for interpreting the behavior of the health care providers. Previous experiences can lead to inappropriate and dysfunctional behavior such as the patient mentioned earlier who didn't share information because he or she thought he or she would be wasting the physician's time. Patients' responses to health care professionals are a reflection of their previous experiences and their imagination of the health care professional's dispositions. Patients who have been treated rather

impersonally by medical personnel are likely to behave rather impersonally in ensuing visits because that's what they believe the health care provider wants.

Analysis: The theory of social decentering posits three methods by which information is analyzed: use of self, use of specific-others, and use of generalized-others. Each method uses both experience-based and imagination-based information as the foundation for the analyses. The application of each form of analysis is context dependent – the appropriateness of counselors self-disclosing their own drug recovery to a client differs from a nurse sharing her experience of breast cancer with a breast cancer patient. The counselor is trying to gain trust and build a relationship on which to build recovery. The nurse is trying to provide comfort and hope. The following discussion should be read with the understanding that the claims and assertions are contextually bound.

Use of self: In a 1991 movie entitled *The Doctor* (based on a true story), a self-centered physician develops cancer and discovers what it's like to be a patient where medical staff show little concern for patient feelings or emotions. His transformation leads him to develop a program to teach his interns the importance of empathy by having them all "admitted" and treated as nondescript patients in a proxy hospital ward. Such an experience develops physicians' ability to incorporate use of self in their interactions with patients. Considering their own reactions to treatment can be an effective base from which to understand and adapt to others.

In *The Doctor*, sensitivity is raised about how medical personnel behaviors affect patients, but use of self can also develop when the health care professional has experienced similar problems as those encountered by patients and clients. This is the reason a number of drug and alcohol counselors are themselves recovering addicts. In a document published by the U.S. National Institute on Drug Abuse, Mercer (2000) wrote:

> Many counselors in this field are either in recovery themselves or have had a family member who was addicted. An indepth knowledge of addiction and the tools for recovery and ability to empathize with the client are essential for an addiction counselor. One way to develop this knowledge and ability is for the counselor to be in recovery. (p. 85)

Counselors in recovery can draw upon their use of self to more fully understand and relate to the experiences of clients with the caveat that the experience of any given client will also be different. Counselors who themselves have not been addicts can still apply use of self by imagining themselves as addicts and in recovery.

The results of interviews with 36 patients who had experienced mental health issues indicated that learning (often through the Internet) that other people have similar mental health issues made them feel they were not alone and that the other people could understand and empathize with them (Powell & Clarke, 2006). This suggests that, in some instances, the use of self would be an effective option for health care professionals even to the point of sharing their own thoughts and feelings with the clients.

The value of use of self for both providing a foundation for understanding and a model of hope and inspiration is one reason there is extensive use of peer recovery support services including therapy groups. Whether it's an AA meeting or a student support group, interacting in a structured format with others who share similar experiences increases the potential for feeling understood by others, finding that someone is not alone in facing the given issue, and gaining strength from others.

Use of specific-other: Many health care encounters initially center on gaining basic information about the client or patient – age, medical and mental health history, current conditions, etc. Such information provides a foundation onto which use of specific-other process can be applied, to the degree that it provides comparisons between patients or clients. That information allows the health care providers to recognize similarities between a given health care user and a previous client or patient. The information from a previous patient or client can serve as the foundation for making predictions and understanding current patients/clients. The effectiveness of the use of specific-other depends on how well developed the use of specific-other is (did it reach RSSD?), how much information has been gathered about the current client/patient, and how truly similar the two are. As more information is learned and the health care professional identifies more similarities, she or he can feel more confident in applying the use of specific-other, or decide that the application is inappropriate. Indeed, dissimilarity can be as informative and helpful as similarity. Dissimilarity leads to efforts to acquire more information about the current health care user in order to understand the differences and more appropriately adapt.

The more experience a health care professional gains, the larger the number of specific-others he or she has from which to draw. For many years my faculty member responsibilities included academic advising. Early on, if students came to me after the semester to talk about their failing grades, I would think about a student I had advised with a similar problem that proved to be because of a lack of studying. That student served as my specific-other and the foundation for understanding and adapting to other advisees with grade problems. That worked fairly well, since failure to adequately study tends to be a general problem. But later in my advising career I was advising a student

who studied hard but was still failing. The experience of my previous specific-others didn't apply and in realizing this, I sought additional information from her. It became clear that college wasn't for her and that she had other aspirations and left school. She then became another specific-other that I drew upon when advising subsequent students for whom aptitude was an issue.

Use of generalized-other: Use of generalized-other is probably the most immediately applied form of analysis that occurs in health care encounters. One reason for this is that a significant part of the education of health care professionals is classification of patients and clients. A therapist draws from a different pool of information with someone identified as having a panic disorder than with someone who is compulsively obsessive. A physician has a different mind-set when dealing with a patient with diabetes than a patient with high cholesterol. Such classifications provide the foundations for the use of generalized-others. The earlier discussion about the lack of empathy among physicians relates to a tendency to primarily rely on and act on the use of generalized-other without utilizing the other two methods. Health care professionals draw on the demographic information, prior diagnoses, and test results as triggers for which generalized-other information to apply. For example, a doctor might simply attribute a 70-year-old patient's vision complaint to aging, but had the doctor conversed with the patient, the doctor might have found out that the patient had considerably increased her needlepointing without the benefit of good lighting. While this is an example of a poor medical exam, it does illustrate how dependence on generalized-others can lead to incorrect conclusions, and stresses how important gaining information is to effective social decentering.

While studying establishes many of the categories applied when dealing with patients and clients, experience leads to their refinement and the creation of the health care professional's own set of generalized categories. Health care professionals need to be keenly aware of applying the use of generalized-other method to understanding and reacting to health care users. Such awareness needs to include comparisons to the use of self and use of specific-other to most fully predict, understand, and adapt to patients and clients.

Relationship-Specific Social Decentering (RSSD): Over time it is possible for a health care provider and a patient to develop an interpersonal relationship that supports the development of RSSD by the health care professional. Developing such relationships is often discouraged particularly because of the possibility of creating dependence and must be balanced with objectively defined roles. The lack of equal power and self-disclosure inherently creates relational inequities. For example, RSSD

is more likely to develop for the health care professionals but not for the clients and patients. RSSD can develop in situations where the health care professionals have an ongoing relationship with the health care user and a significant amount of knowledge is learned about the user. But unlike most interpersonal relationships, RSSD in health care relationships represents a unilateral form of RSSD wherein the health care professionals know the clients intimately, but clients have limited personal knowledge of the professionals.

I have had the same general practice physician for 30 years and he knows I enjoy camping and hiking in the national parks and playing basketball, that provides him a degree of RSSD, but I have also learned that he enjoys these things. In my yearly checkups, he not only engages me in discussion of these areas, but uses that discussion as a way of assessing both my mental and physical health. Happily, despite the occasional injuries and aches, he continues to encourage me to play basketball as part of his medical advice. Fortunately, it doesn't take 30 years for a health care professional to learn enough from a patient or client to establish some RSSD, but I have also learned that he enjoys these things. Each piece of new information acquired allows for better understanding and adapting to the health care user. Finding out a health care user's mother died two weeks before, becomes a piece of information specific to that user that allows the health care professional to consider the impact of the mother's death on the user relative to other information already known. If sufficient RSSD has developed, the health care professional should be able to predict and assess the impact on and response of the user based on this new piece of information.

Unlike most of our interpersonal interactions, health care professionals usually review the notes and charts that have been made about their patients or clients before each encounter. Such a review is one way of activating the relationship-specific level of information that has been collected but not committed to memory. Some personal information is not recorded and thus depends upon the health care professionals' recollections, that is particularly challenging for those with a large patient or client lists. Nonetheless, such notes bolster the ability to engage in RSSD. As patients, we feel personally validated by a physician who begins the encounter by asking how we are doing relative to some prior diagnosis or treatment; unlike the feeling we have when a physician begins the encounter and is clueless about who we are or what we need.

Overall, health care professionals need to recognize that they should try as much as possible to develop a schema for each of their patients or clients if they wish to fully and successfully engage in other-centeredness. Once recognized, health care professionals need to make a conscientious effort to create and apply RSSD. The shorter time between encounters the easier it is to develop RSSD, such as in weekly therapy

sessions; but at the same time, the health care user's expectation for understanding and adaptation will also increase. Such expectations are akin to those that occur in interpersonal relationships as the provider-user relationship becomes more long-term and intimate. On the other hand, the longer the breaks between user and provider encounters, the more forgiving the patients and clients will hopefully be regarding the health care provider forgetting personal information.

Output – Cognitive and Affective: The analysis of information leads to both cognitive and affective responses within the social decenterer. The cognitive response includes predictions, understanding, and development of potential strategies. The affective response includes the decenterer's own feelings about the situation that might include sympathy for the other person. The affective response might also include having similar emotional reactions to the situation as the target – what I consider truly to be empathy. On the cognitive side, health care providers develop an understanding of the behaviors and feelings of their clients and patients. Providers can use social decentering to predict the reactions of users to diagnoses and proposed treatments and to develop the most effective strategy for presenting those to the users. On the affective side, health care providers must consider whether to share their own emotional reactions to the health care users' situation. While such expression can potentially build trust, it can also stifle communication because some emotional disclosures by the provider might seem judgmental. When the health care professionals' emotional responses are empathetic, they enhance the cognitive process by providing insights about the user's emotional experience. Providers who express their empathy can confirm the user's own feelings, demonstrate effective listening, and create a supportive climate for further user disclosures.

Unfortunately, there is a downside to the affective experiences of health care professionals – burnout and fatigue. The experience of constant emotional arousal of negative emotions (sadness, anger, frustration, sorrow, helplessness, etc.) as the result of social decentering or empathy can lead health care providers to emotional exhaustion, compassion fatigue, and burnout. In addition, showing empathy and concern while repressing other emotions such as sadness and anger creates emotional labor leading to stress and exhaustion (Wright, Sparks, & O'Hair, 2013). A considerable amount of research has been done specifically on compassion fatigue among health care providers. Compassion involves an awareness of and desire to address another person's suffering (Sinclair et al., 2017). Compassion can be thought of as one of the products of social decentering in which an individual recognizes another person's situation (suffering), feels an emotional response to that perception, and then

responds with an effort to help the person manage the suffering. Unlike other social decentering responses that are not expressed or exhibited, an important component of compassion is the action step. The emotions evoked through social decentering in response to other people's suffering are likely to contribute to compassion fatigue. A Portuguese study of 280 nurses found that empathic concern (assessed with the Davis subscale) was a significant predictor of compassion fatigue (Duarte, Pinto-Gouveia, & Cruz, 2016). In a review of research on compassion fatigue, Sorenson, Wright, and Hamilton (2016) found that a variety of similar conditions fall under different labels such as compassion fatigue, compassion stress, secondary traumatic stress, and burnout. Their review of studies across the spectrum of health care provider roles found that compassion fatigue and related conditions produced negative physical, emotional, and work-related effects, reduced the ability to feel empathy, and affected interactions with co-workers and patients. Additional effects of compression fatigue, burnout, and emotional fatigue include negative impact on personal life, heightened concern for one's own health, reduced job satisfaction, and quitting one's job.

Among the methods Sorenson et al. (2016) identified to counter compassion fatigue were educational interventions, supportive working environment and management, and compassion satisfaction (feeling positive about one's contributions). Duarte et al. (2016) found that self-compassion moderated the effects of empathic concern and personal distress on compassion fatigue. Self-compassion involves the ability of people "to be caring, supportive, and understanding toward themselves, particularly when faced with suffering or failure, and who feel interconnected with other people" (Duarte et al., 2016, p. 8). In terms of social decentering, individuals can choose not to engage in an analysis of the client's or patient's situation. However, such decisions can move the provider back to the impersonal, clinical treatment of others. Health care providers need to recognize those situations that will benefit from their engaging in social decentering and those for which it is less consequential.

In so doing, the level of emotional exhaustion can be reduced. A social decenterer's sense of self-worth can also be bolstered by applying social decentering to an analysis of their own contributions toward helping and comforting others and the positive impact that they had.

As in other contexts, the issue of whether empathy and perspective-taking are cognitive or affective is debated within the health care context. In applying empathy to health professionals, Hojat (2016) defined empathy as a cognitive process that results in understanding a patient's perspectives and experiences and communicating that understanding to the patient for the purpose of helping the patient. Hojat equates

emotional empathy with sympathy and warns that excessive sympathy can be detrimental to health care professional decisions.

Hojat (2016) emphasized understanding emotions by health professionals over actually experiencing emotions. In the model of social decentering, the line that connects the cognitive response to the affective response reflects Hojat's thinking about emotions. While we can "think" about another person's emotional disposition, we should also recognize that almost all humans will also have an emotional reaction to the information they are processing. Hojat's concern appears primarily to be that the health care provider's emotional responses not interfere or undermine subsequent treatment.

Rather than denying the emotional reaction, health care professionals need to recognize their reaction and determine the degree to which it is affecting them. One rule for dealing with emotions in conflict is deciding whether to express that emotion to the other person (Beebe, Beebe, Redmond, 2017). Similarly, health care professionals might choose to share their emotional reactions to the patients or clients as a genuine demonstration of concern and empathy. For example, it might be appropriate for a physician telling a long-time patient that he has terminal cancer to also express her or his own feelings of sadness and loss while providing comforting messages.

Strategies/Responses: Recall that individuals often engage in social ecentering without displaying apparent adaptive behaviors. One reason for not displaying adaptive behaviors is a lack of responsive skills in the social decenterer. A nurse might feel ill at ease giving a patient a hug even though the nurse recognizes it would be comforting to the patient. Much of the interpersonal training of health care professionals is designed to overcome this limitation by providing training in responsive and empathic behaviors. A second reason for not displaying adaptive behaviors is strategic; displaying understanding might actually create stress for the recipient. Most of us don't like it when someone declares that they know what we're thinking – we don't like people reading our minds. Health care professionals are often in the position of having to repress their empathic impulse when they realize it would be detrimental to a user's health care or therapy. Elliott, Bohart, Watson, and Greenberg (2011) saw such a need for therapists to tailor their empathic responses to the clients:

> Therapists therefore need to know when – and when not – to respond empathically. When clients do not want therapists to be explicitly empathic, truly empathic therapists will use their perspective-taking skills to provide an optimal therapeutic distance in order to respect their clients' boundaries. (p. 48)

Elliott et al. implicitly identify the production of both affective and cognitive output; such output is part of the social decentering process. Social decentering by health care professionals includes the emotional reactions experienced by the health care professional and the cognitive analysis of how various different responses might impact the patient or client, including the therapists' expression of their own emotions. Such skill is critical to the success of most health care interactions. In writing about therapists' responsiveness skills, Hatcher (2015) wrote: "Responsiveness may be continually informed by new experiences with others, and enriched by strengthening and modifying existing interpersonal skills" (p. 748). For such strengthening to occur, health care professionals need an awareness and openness to the information afforded in new experiences and adding it to their experience-based information archive.

Bylund and Makoul (2005) examined the actual communicative behaviors of 20 academic primary care physicians in response to patients' explicit statements of emotion. They found that 30.3 % of the time, physicians acknowledged the emotion, 28.2% of the time, they pursued the emotion with questions or advice, and 26.5% of the time, they confirmed the legitimacy of the emotion. Rarely did physicians express a shared feeling or experience, give an implicit or perfunctory reply, or deny the emotion. While such responses demonstrated effective listening and confirming responses, they do not really prove the physicians engaged in empathy, perspective-taking, or social decentering. Statements that reflect an understanding of the emotion within the terms of who the other person is would be stronger indices of the physician actually being other-centered. Interestingly, Bylund and Makoul found patients didn't provide physicians many opportunities to respond to the patients' emotions, with 40% of the patients making no emotional statements and 60% averaging only two and a half statements regarding their emotions. While not the intent of the study, it does reinforce the point made earlier that patients are reluctant to self-disclose, thus limiting the ability to socially decenter. In addition, patients were more likely to share negative feelings while physicians were more likely to respond empathically to patients' positive feelings. The authors suggest that physicians might either be trying to remain calm and thus neutralize the negative feelings or feel ill-suited to address the negative feelings. The second suggestion is in concert with the notion that people can engage in social decentering yet lack the wherewithal to appropriately respond.

Suchman, Markakis, Beckman, and Frankel (1997) also examined missed empathic opportunities and developed an interactional model that reflects how patients' emotions come into play when interacting with physicians. First, they observed that patients rarely articulated their emotions initially but provide indirect verbal and nonverbal clues. Next, empathic clinicians pick up these clues and invite exploration of what the

patients are feeling. Once expressed by the patients, clinicians provide confirming responses that convey understanding of the patients' feelings. Suchman et al. also observed that when patients re-introduce an emotion to the conversation that was not initially acknowledged, they likely are signaling that the emotion is important to them and needs to be acknowledged and explored. Suchman et al. also noted that clinicians need to continue to invite their patients to elaborate on their feelings before the clinicians state their understanding. If a health care professional expresses understanding before the patients have fully shared their feelings, the professional implicitly signals an end to the discussion and thus subverts full exploration of the patient's emotions.

Training Health Care Professionals to Socially Decenter

Teding van Berkhout and Malouff (2016) reviewed extant studies and concluded "empathy training programs tend to be effective in increasing empathy levels. The present overall results suggest that it could be worthwhile to train individuals in empathy and to evaluate, at least informally, the effects" (p. 39). An examination of a recent training study provides an example of what often occurs in empathy training. Ruiz-Moral, Pérula de Torres, Monge, García Leonardo, and Caballero (2017) implemented and successfully tested a training program for third-year medical students that was organized as a sequential "empathic process." Students first learned to identify affective and contextual cues, then they learned communication skills to more deeply explore the patients' illness experiences, and finally they were taught to make empathic statements. As in the definition of social decentering, their training began with an observation of some trigger (e.g., nonverbal emotional cues) and the consideration of the context. Response to these cues led to collecting more in-depth information. This training program like many others focuses on identifying an emotional marker, seeking elaboration from the patient, and providing confirming empathic statements such as "I understand you feel frustrated." This program recognized the need for the students to understand the patients' experience but that was only measured in terms of empathic statements. Such training moves from activation triggers to empathic statements without necessarily engaging in social decentering, empathy, or perspective-taking. Students need to consider the patient's thoughts, how the patient differs from other patients, and how they would feel in the patient's situation, which perhaps the training included. The challenge of training is teaching students to understand the patients or clients' dispositions and when appropriate, genuinely convey their sense of understanding and feelings.

For health care professionals, to socially decenter means more than just recognizing, acknowledging, and sympathizing with patients or clients' emotions; it involves a broader understanding of who the patient is and how the patient thinks. Training needs to include developing mental schemas of patients and clients and using those schemas to interpret, understand, and respond to their statements and behaviors. But the health care professional must seek a balance between the sensitivity/connection achieved through social decentering and the objectivity/detachment needed to make sound decisions. One format for training that I have used with students involves briefly interacting with another person who provides a minimal description of a personal issue. The decenterer is then asked a series of questions that encourage them to first consider the information they have about the situation and the person, what additional information they might need, and how they might acquire that information (e.g., additional background information, probing questions, and use of dyadic self-disclosing). Next, they are asked to consider the person and his or her situation using each of the three methods of analysis: "What would they think and feel if faced with a similar situation?", "What do they believe this other person is thinking and feeling?". and finally, "What would most people in general think and feel?" (a full set of social decentering reflection questions appears at the end of Chapter 5). Finally, the target person provides feedback about the accuracy of the assessment. The goal of the activity is to have students consciously engage in social decentering and assess the degree to which they understand the thoughts and feelings of another person. Additionally, trainees should consider, and practice response strategies based on their analysis including the use of confirming and supportive statements when appropriate.

Groups/Teams

Groups represent "interpersonal communication among three or more people who view themselves as a group and who are working toward a shared purpose or goal" (Redmond, 2000a, p. 256). Thus, groups include such entities as families, committees, workgroups, and project teams. The terms groups and teams are used interchangeably in the following discussion. Group and team goals and interactions have two orientations: task and social (relational/emotional) (Redmond, 2000a). Teams with goals of policy-making, decision-making, or problem-solving tend to be highly task-oriented. Groups that exist primarily to satisfy needs for companionship, belonging, and personal confirmation are highly social and relationally oriented. Task- oriented groups are not devoid of social/relational goals nor are social groups devoid of tasks. Other-oriented processes such as social decentering can contribute to successful completion of both task and social/relational goals. Tompkins (2000) argued that for

teams to develop well-functioning relationships they need, "The ability to empathize and listen to team member's ideas and the ability to respond" (p. 214). In identifying qualities needed for effective teams, Borrill and West (2005) wrote, "Team members must be able to 'decentre', to take the perspective of others into account in relation to both their affective and cognitive position" (p. 145).

Empathy, particularly when conceptualized as an affective process, has an obvious connection to the socioemotional factors that contribute to group process. Perspective-taking, on the other hand, appears more connected to understanding other group members, and could help improve task and leader efficiency. As both a cognitive and affective process, social decentering facilitates both the social and task goals. Kellett, Humphrey, and Sleeth (2002) found a positive correlation between group members' perception of another member's empathy ("shows sensitivity and understanding" p. 531) and their perception of his or her leadership. Kellett et al. felt there were two behavioral routes to being perceived as leaders: empathic behaviors and mental abilities. Empathy was seen as important to leaders because "perceiving others' feelings and empathizing with them is likely to establish an affective bond or relationship that offers benefits for leadership" (p. 536). While they emphasized the emotional part of empathy, their measure included items focused on a member's level of understanding and, as such, is similar to the social decentering measure.

Pescosolido (2002) and Wolff, Pescosolido, and Druskat (2002) present a case for a type of emergent leader who manages both the group's task and the emotional state. Such leaders display emotional reactions that cue other members' emotional reactions and thus influence group performance. Such management occurs because strong empathic skills allow these leaders to better understand and identify the needs of the group members. Such understanding has task implications by contributing to improved problem-solving. Empathy allows leaders to develop strategies that are adapted to the emotional states of the members and thus, to the degree that management of emotions is relevant, improve group productivity (Wolff et al., 2006). Wolff et al. don't limit empathy's impact to emotional processes but instead argue that empathy also strengthens effective perspective-taking by the leaders. Their combination of empathy and perspective-taking constitutes the same social cognition process that makes up social decentering. Social decentering can thus be expected to aid emerging leaders in successfully adapting to the emotions and thoughts of the group members.

Other-orientation has an impact on the emergence and effectiveness of team leaders. Dugan, Bohle, Woelker, and Cooney (2014) argued that social perspective-taking (concern for others) contributes to self-understanding relative to others, thus fostering social bonds and less in-group favoritism, which in turn enhances one's ability to

function in groups. Textbooks on effective decision-making groups and leadership often advocate learning about and adapting to other group members. For example, Young, Wood, Phillips, and Pederson's (2001) guide to group discussion emphasizes the need for a leader to recognize and appreciate the diversity among group members – leaders need to "adapt their actions not just to the group as a whole, but also to the needs and preferences of individual members – a challenging task" (p. 50). They also emphasize the need to analyze and adapt to the situation, a key component of social decentering. To apply social decentering to groups, leaders need to learn about and adapt to group-specific member variables. These variables include members' reasons for participating in the group, members' stakes in the issues facing the group, the skills members bring to the group as well as their limitations, and members' involvement in and commitment to the group (Young et al., 2001). Analysis of these variables benefits from the application of social decentering but also contributes to social decentering.

One of the main reasons groups are utilized for decision-making and problem-solving is the value that accrues from tapping a diverse set of perspectives and skills. But that diversity is also problematic because it can block effective interactions and the establishment of productive relationships, as well as become a source of tension and conflict. A focus on differences can foster bias, disrespect, and intolerance. Members might find it difficult to carry on conversations with other members who hold contrasting perspectives preventing them from seeing each other's viewpoints (as demonstrated for example, in the US Congress, the British Parliament, and the German Bundestag). Hoever, van Knippenberg, van Ginkel, and Barkema (2012) identified perspective-taking as a significant way to offset the problems associated with diverse perspectives. They argue that through reciprocation, perception-taking emerges as a team process that "helps teams to capitalize on their diversity on creative tasks by fostering the sharing, discussion, and integration of diverse viewpoints and information" (p. 984). Further, they argue that efforts to understand a teammate's perspective leads to both active and passive information seeking. Hoever et al. also point out that in homogenous teams, perspective-taking would not be particularly beneficial. In essence, homogenous perspective-taking would be akin to the use of self method of social decentering. Contrary to Hoever et al., the harm of such homogeneity is not in undermining perspective-taking but in creating groups that lack the benefits of diverse perspectives. Hoever et al.'s study found that perspective-taking in diverse groups had a positive effect on information elaboration and creativity. Just as social decentering requires cognitive effort and thus motivation to do so, Hoever et al. noted that one role of a transformational leader would be to motivate diverse members to make the effort to consider their teammates' perspectives.

Besides the use of social decentering, group members can also develop and apply RSSD. The depth of RSSD that is developed with each of the other members is dependent on self-disclosing, the behaviors exhibited by each group member, and additional interactions outside the team. The knowledge learned about each member provides a foundation for adapting to each member's unique characteristics. Such skill is particularly valuable to team leaders who need to effectively interact with all members. But adapting to members who are quiet and fairly inactive obviously limits both the use of social decentering and the development of RSSD.

Just as RSSD can be developed with each of the group members, a form of social decentering can be developed based an understanding of the group as a whole – in essence, group-specific social decentering. We develop a sense of how a certain group of people behave, think, and feel. For example, you might consider a work project team that you're in as dysfunctional with too many egos and everyone trying to outdo the others. This understanding of the group should help you accomplish your goals by selecting strategies adapted to this group. Seeing the group as a single entity for which we have a positive regard is likely to lead us to describe the group as a team or family. Think about the groups or teams in which you have been a member. Do you have a mind-set that describes those groups as a whole? Do you compare and contrast the groups you are or have been in? To form such group-specific social decentering, members need to have shared their thoughts and feelings. Since members are likely to vary in terms of how much they are willing to share, group-centered social decentering will be incomplete and its effectiveness limited. Rico, Sanchez-Manzanares, Gil, and Gibson (2008) identify trust as a significant factor leading to members opening up about themselves, "trust promotes the information exchange between team members necessary to integrate their different perspectives on the situation into a common understanding" (p. 172). In turn, perspective-taking enhances understanding of other members' messages, intentions, and interpretations (Rico et al., 2008).

Social decentering can impact groups and teams in terms of the effectiveness of task and social leaders and in terms of the social decentering skills of the group members. To examine these issues, I conducted a study in which 74 students from three upper-level communication courses worked in 16 problem-solving groups of three to six members for two to four weeks. Each group produced a paper and made a presentation to the class. At the completion of their project they completed the social decentering questionnaire, the Group Attitude Scale (Evans & Jarvis, 1986), a measure of perceived quality of discussion (adapted from Gouran, Brown, & Henry, 1978), and a measure of the quality of group behavior dealing with relevant and systematic discussions and healthy interpersonal relationships (Gouran et al., 1978). Each member

identified who they felt had been (1) most influential, (2) provided the most guidance/ direction, (3) showed the greatest concern, and (4) was the overall leader. Members identified by 40% or more of the other members on a given item were considered a leader on that item. Social decentering scores were used to divide those leaders into two groups: high and low social decenterers. Social decentering did not impact the emergence of task leaders; the social decentering scores of members identified as leaders for influence, guidance, and overall leader were not significantly different from nonleaders. Those identified as showing the most concern for other group members were significantly stronger in social decentering than other members ($t = 1.68$, df = 65, $p = 0.04$). The skills needed to manage the task aspects of group activity appear unaffected by the level of social decentering held by task leaders or overall leaders. Apparently, the emotional component of social decentering comes more into play in helping strong social decentering leaders' effectively convey feelings of concern to other members.

While social decentering did not impact the emergence of leaders, it did impact the perceived quality of the interactions. Members reported greater team attraction in those groups with high social decentering task leaders (influence, guidance, and overall leader). Members perceived higher quality of discussion in groups with high social decentering influential leaders and guidance/direction leaders. No such impact on interactions was found for high social decentering/high concern leaders.
As in previous studies, quality of interaction was more related to effective task management than to social-emotional management.

Besides the impact of a leader's level of social decentering, the overall members' level of social decentering among the group members is also likely to impact their interaction and success. Groups where all the members are strong at developing an understanding of the other group members should produce a more positive climate than groups where members are less sensitive and adaptive to each other. In the above study, the average social decentering scores were calculated for each of the 16 groups and the groups divided into the eight highest and eight lowest social decentering groups. Members in groups with the higher social decentering averages reported stronger attraction ($t = 1.43$, df = 70, $p < 0.10$), higher quality discussion ($t = 2.84$, df = 70, $p < 0.01$), and more positive group behaviors ($t = 1.32$, df = 70, $p < 0.10$) . While this study is limited in both the number of groups examined and in controlling the social decentering composition of the groups, the results support the overall contention that the social decentering levels of leaders and team members impact the member's perceptions and feelings about the group.

Another study that examined how member qualities affected the group process was conducted by Falk and Johnson (1977). They created 30 groups of students who engaged in the NASA decision-making task. Half the groups were given perspective-taking instructions that explained several steps to follow in order to better understand and convey understanding of the other member's viewpoints and information. The other half of the groups received egocentric instructions that emphasized pushing for their own solutions. Compared to the egocentric groups, the perspective-taking groups produced better and more creative solutions, utilized member resources better, felt more commitment and satisfaction with the solution, had less conflict over the ideas presented, and reported greater trust in one another.

The influence of social decentering on fostering positive climates should result in social decentering having a positive indirect effect on decision-making and outcomes as found in the Falk and Johnson study. Such influence is likely to be the strongest when the group task is one that requires the leader and group members to understand and appreciate each other's perspectives and goals. In many ways, groups are sets of interpersonal relationships and thus the factors that influence the success of interpersonal relationships also affects the success of groups and teams. Thus, the application of social decentering and RSSD in teams is an extension of what occurs in interpersonal relationships.

Organizations/Managers/Leaders

Interactions and relationships in organizations fall into the two broad categories – personal and professional – which are not mutually exclusive. On the personal level, members of organizations form friendships and romantic relationships and in general apply social decentering and RSSD in the manner discussed earlier about such relationships. Since personal relationships occur within an organizational context, decentering includes the added focus and sensitivity about how one's partners are affected by the organization itself. These relationships provide members with social support and organizational support, and help in managing organizational change (Beebe, Beebe, Redmond, 2017), which in turn, are enhanced by social decentering and RSSD.

Co-workers are in a position to more readily relate to and understand the impact of common organizational problems and issues on each other (e.g., a difficult boss, changes in company policy, or issues of scheduling or pay). Co-workers are often in a better position to socially decenter with other co-workers than their friends and romantic partners who work elsewhere. The commonality of their experiences makes

the use of self-method of social decentering a fairly effective option as co-workers commiserate or celebrate organizational events that have a similar impact on both.

Parker, Atkins, and Axtell (2008) broadly defined perspective-taking as both an affective and cognitive process of understanding others as they examined its application to organizations. They noted that "Given its effect on communication and other fundamental interpersonal processes, perspective-taking is likely to enhance the performance of all roles within organizations that have a strong interpersonal requirement" (p. 159). Parker et al.'s review of perspective-taking research identified such benefits in organizations as messages framed for others to more easily understand, fostering self-disclosure by others, improved interpersonal problem-solving, greater trust, and less interpersonal aggression.

The professional relationships in organizations are formal relationships defined by the positions that individuals hold, most notably, those of supervisor and subordinate. Each position usually includes a set of expectations to whom and how individuals communicate and behave toward each other. For example, communication from managers and supervisors to subordinates usually revolves around providing instructions, rationales, policies, appraisals, and information to help develop and fulfill the organization's mission/vision (Beebe, Beebe, & Redmond, 2017). Formal organizational relationships are often grounded in who has power or decision-making responsibility over other employees. Even among peers, communication and responsibilities are tied to seniority and status. Power can have a negative effect on people's enactment of social decentering and RSSD by increasing egocentrism and self-interest.

The structure that dictates the formal communication within organizations falls into specific directional categories: downward – superior to subordinate; upward – subordinate to superior; horizontal – peer to peer; and outward – internal to external (customers/suppliers). For each of these, social decentering and RSSD can enhance both the personal and professional interactions. On the other hand, the nature of organizations and their culture might inhibit the development and/or application of social decentering and RSSD. The managerial culture of an organization might discourage managers from seeking to understand subordinates' personal problems and feelings.

Within downward communication, social decentering and RSSD center primarily on managers' performance of their responsibilities with their subordinates. For leaders, social decentering and RSSD can be significant tools that allow them to emerge as leaders and foster followership. The terms, managers and leaders, are sometimes treated as interchangeable. But in this discussion, I will treat these as two separate roles.

You can have managers who are not leaders and leaders who are not managers. Managers are assigned to play a particular role and perform particular tasks and whom subordinates follow because the manager controls resources (e.g., pay and work schedule) wanted by the subordinates. Leaders are people to whom others turn for guidance and direction and who inspire others to follow them. Ideally, managers are also leaders, while leaders often emerge among nonmanagers.

Managers are given position power that allows them to influence and direct others. Having power provides both assets and liabilities. Research suggests that power tends to undermine perspective-taking and empathy. Within organizations, this means that the more power individuals have the less likely they will be to engage in social decentering. Robert Sutton (2009) wrote in the *Harvard Business Review* that "people who gain authority over others tend to become more self-centered and less mindful of what others need, do, and say" and that "bosses tend to oblivious to their followers' perspectives" (p. 44). Similarly, Galinsky, Jordan, and Sivanathan (2008) observed that "The powerful appear to be particularly poor perspective-takers. Indeed, power appears to reduce social attentiveness, placing a blind spot on considering the unique vantage point of others" (pp. 289–290). Galinksky et al. add that powerful people fail to recognize that others don't share their privileged perspectives and that they are less perceptive of and influenced by others' emotions. Managers appear susceptible to these limitations in contrast to the impact on leaders. Galinksky et al. contend that power and leadership are separate constructs and that effective leaders are "able to harness the positive psychological effects of power while mitigating the negative ones" (p. 283). Thus, leaders are distinguished from managers in that, despite their power, they continue to engage in social decentering toward those around them. To maintain social decentering, leaders and managers need to offset the negative influence of power.

The impact of power can apparently be mitigated through the use of perspective-taking. Galinsky, Magee, Rus, Rothman, and Todd (2014) conducted three studies in which they primed participants to take another's perspective. In one study that involved solving a murder mystery, pairs of students were randomly assigned to be the subordinate or the boss. The boss was described as directing, evaluating, and rewarding the subordinate. Each partner received shared clues and one received several more unique clues, including key information needed to solve the mystery. Primed participants were instructed to perspective-take by considering their partner's perspective. Nonprimed participants were instructed to consider a time where they successfully took another person's perspective. Pairs were given 10 minutes to solve the mystery. Bosses primed to perspective-take discussed their unique clues more with their subordinates than did nonprimed bosses. Subordinates discussed more of their

unique clues to their bosses who had been primed to perspective-take more than subordinates with nonprimed bosses. No effects were found in discussing clues by subordinates who were primed to perspective-take and those who weren't. Similarly, pairs with primed bosses picked the correct suspect 63% more often than the pairs with nonprimed bosses. The perspective-taking of the subordinate had no such effect on accuracy. These differences between the boss and subordinate supported the claim that perspective-taking mitigated the tendency of those in power to be egocentric and controlling.

Galinsky et al.'s study should not be taken to mean that everyone who is primed can engage in perspective-taking. Individuals vary in their perspective-taking and social decentering abilities, and priming is unlikely to radically improve a person's ability. Priming might act as a trigger that reminds and motivates those with perspective-taking or social decentering ability to tap those resources. The average of primed skilled and unskilled participants is likely to produce greater positive impact over a nonprimed group but not all of the primed participants necessarily engaged in perspective-taking. Two factors appear to affect the engagement in other- centeredness – priming and power. Both factors appear to affect the motivation needed to activate perspective-taking or social decentering.

Power also seems to affect motivation of those low in power who might feel it is not worth their time and energy to engage in social decentering. Engaging in social decentering might even lead to the decision not to act. For example, social decentering subordinates' analysis of their bosses could lead to a decision not to share certain information because they know the boss will disregard it (this construct is often reflected in the *Dilbert* cartoon). Power can thus inhibit the open flow of information from subordinates to managers. Milliken, Morrison, and Hewlin (2003) found that being silent was a common experience for 85% of the employees they interviewed; primarily, because they felt the managers did not want to hear about problems or that the managers would react negatively. In other words, the social decentering ability of subordinates led to conclusions about negative managerial response that rested in the power the manager possessed. To offset this, managers need to foster relationships that minimize the negative impact of their position power, demonstrate their openness to input from subordinates, and develop and engage in social decentering.

Upward communication involves efforts by subordinates to interact and influence their managers. Despite the negative impact of power, subordinates are likely to be motivated to socially decenter with their managers when they have strong personal reasons for doing so. Seeking approval for a project, asking for a pay raise, or requesting time off might motivate subordinates to use their understanding of their managers to

develop the most effective and appropriate compliance-gaining strategy. Employees who know their managers well are in a better position to develop and apply social decentering than newer employees or employees who have not garnered sufficient information about their managers. Such information is accrued by personal interaction and observation of the managers as well as from co-workers. New employees often turn to current employees to find out what the manager is like.

Gregory, Moates, and Gregory (2011) examined the relationship between managers' level of dyad-specific perspective-taking and the transformational and transactional styles of leaders. Dyad-specific perspective-taking is like RSSD, in that the focus is on how well managers feel they know a particular employee. RSSD's balance between the cognitive and emotional sensitivity makes it a broader measure of orientation than the dyad-specific perspective-taking measure created by Gregory et al. Two qualities of a transformational leader that seem most strongly related to other-orientation are inspirational motivation (accurately communicating a vision to followers) and individualized consideration (concern with followers' developmental needs and willingness to provide support toward the followers' goals) (Gregory et al., 2011). Perspective- taking and social decentering provide a foundation for managers to develop strategies to inspire and effectively adapt to subordinates' professional and personal needs and goals. Accomplishing these contributes to the perception of the manager as a transformational leader. Gregory et al. had 23 supervisors rate their dyad-specific perspective-taking with up to five subordinates and had the 83 subordinates rate the supervisors' leadership. They found that managers' dyad-specific perspective-taking positively influenced the subordinates' ratings of their bosses' transformative leadership but not for transactional leadership. The researchers found variation in subordinates' ratings of the same manager which meant managers developed dyad-specific ratings with some subordinates and not with others. Variations in the manager's use of dyad-specific perspective-taking suggests dyad perspective-taking is not the same as the trait behavior associated with general perspective-taking. This is congruent with the proposition that individuals who are not necessarily strong in general social decentering can nonetheless develop RSSD. Managers' knowledge and understanding of their subordinates varies and thus their development of RSSD varies. As a result, managers are more adept at adapting to some employees than to others which creates variation among the subordinates' perceptions of their managers' leadership style. Perhaps your perception of a given manager has differed from your co-workers' perceptions – where you have felt inspired and supported and your colleagues did not (or vice versa). Managers with strong RSSD are aware of the thoughts and feelings of

a given employee and are able to develop an effective strategie tailored to inspire and motivate that subordinate.

Leader-member exchange (LMX) theory centers on explaining how supervisor-subordinate relationships vary in type and quality. High-quality relationships are characterized by mutual trust, respect, and support while low-quality relationships stay within assigned roles and task responsibilities (Beebe, Beebe, Redmond, 2017). Those in high-quality relationships are found to be more satisfied, more committed, and more productive. But research by Fix and Sias (2006) indicates that subordinates' perception of supervisors' person-centeredness apparently mediates the effect of LMX. Person-centeredness can be thought of as the degree to which one's communication reflects adaptation to another, as such, it represents the output of the social decentering process. Fix and Sias had employees write out what they felt their supervisor would say to them if their unit was restructured and their job redesigned. Participant responses were coded for the degree to which they reflected person-centeredness on the part of their supervisor. Perception of supervisor person-centeredness positively impacted the perception of the quality of the leader-member relationship and was more strongly related to job satisfaction than LMX. Fix and Sias concluded that person-centeredness has benefits both for the employees (satisfaction, commitment, and autonomy) and for the supervisors (lower turnover and higher productivity). Supervisors who are strong social decenterers and those who have developed RSSD with a subordinate are in a position to produce person-centered messages that result in stronger LMX relationships and thus acquire its accompanying benefits.

Besides improving the relationships, the ability of managers and leaders to engage in social decentering and RSSD should be an asset to their ability to manage subordinates. Understanding the dispositions of employees provides a foundation for developing and applying effective management strategies. After reviewing extant research, Kellett et al. (2002) concluded that empathy provides leaders with knowledge and understanding that enables "leaders to influence follower's emotions and attitudes in support of corporate goals and objectives […]" (p. 528). Remember, however, that there is one set of skills for understanding and analyzing strategies and another set of skills to enact strategies. Ku, Wang, and Galinsky (2015) thoroughly reviewed perspective-taking research in developing a model of perspective-taking in organizations. The model identifies the numerous benefits of perspective-taking by managers and leaders such as increasing liking, reducing stereotyping, improving distributive and integrative negotiations, and increased helping behavior. Parker et al. (2008) suggest that organizations interested in reducing stereotyping among all

employees would benefit from enhancing employee perspective-taking rather than their efforts to suppress stereotyping.

Ku et al.'s (2015) model also identified factors that can lead to unintended negative consequences of managers and leaders use of perspective-taking; for example, giving preferential treatment, making negative inferences (among managers with low self-esteem), developing a less positive view of stereotypically positive targets, and engaging in egotistical and unethical behaviors when the target is perceived as competitive. Their identification of negative consequences of perspective-taking coincides with my observation that being other-centered and engaging in social decentering can intentionally be used not just to benefit others, but also for personal and selfish gains with possible negative consequences for others. Parker et al. (2008) recognized that perspective-taking could be used for personal gain to the detriment of others such as sales staff getting buyers to purchase things they don't need or managers manipulating subordinates.

Another negative repercussion of social decentering and RSSD is leading managers and leaders to make decisions that are detrimental to the organization. Social decentering and particularly RSSD can lead managers to not only empathize but also to sympathize with subordinates' personal life challenges. Knowledge of a subordinate's problems might result in a decision that supports the subordinate while undermining the goals and productivity of the organization. For example, letting an employee continue to arrive late to work because of problems at home reduces productivity, and the special treatment might lower the morale of other employees. Payne and Cooper (2001) observed that acting "negatively toward an employee, even when justified, requires that supervisors set aside or distance themselves emotionally from the tendency to empathize" (p. 73). They point out that some people are unable to detach themselves from empathizing and thus represent a person-job misfit. Indeed, constantly having to make dispassionate decisions with subordinates with whom a manager has developed strong RSSD can create stress and even burnout. Making decisions that favor the organization over the individual becomes another challenge created by social decentering. Decisions favoring the organization might reflect the path most likely taken by a manager while standing behind decisions favoring the individual is the path taken by a democratic leader.

Ku et al. (2015) identified factors that are likely to elicit the more selfish application of perspective-taking, including low moral concern and strong drive for personal success. Strong social decentering managers/leaders with low moral concern and strong personal success drive might be more inclined than others to utilize their understanding of others to develop and apply strategies for personal gain, sometimes at the expense

of others. Because I recognized these dangers, over my years of teaching, I explained the power and influence that students could gain by becoming effective in social decentering, but I also stressed the need to be ethical in its use – not using it to exploit others.

The popular people styles inventory (Bolton & Bolton, 2009) classifies workers according to four styles: analytical, driver, expressive, and amiable. In examining the role of people styles in the workplace, Bolton and Bolton see empathy as a key quality associated with the amiable style. Amiables are people-oriented, friendly, and personal. Bolton and Bolton explain that in applying empathy, amiables are:

> […] concerned about what other people think and want. They're often more interested in hearing your concerns than in expressing their own. Amiables are especially sensitive to other people's feelings. They're more likely than people of other styles to be able to vicariously put themselves in another person's shoes. (pp. 54–55)

Interestingly, no real connection has been made between perspective-taking and the four styles. But one of the major themes of Bolton and Bolton's book is for people to recognize the styles of their co-workers and adapt to them. They provide advice for people in each style about how to adapt to other styles. In other words, they are promoting perspective-taking and social decentering as critical skills for working with others. For example, amiables are advised to "be more task oriented," "de- emphasize feelings," "be systematic," and to "be well organized, detailed, and factual" (pp. 156–158). They are suggesting that amiables turn down their empathy and adapt a more analytic style. Inherent in social decentering is the ability to reach such conclusions about adapting your style to others in the workplace. Use of self gives insight of how your style affects your responses and then to recognize the different styles and responses of others, thus providing a foundation for strategic adaptation. Understanding the effects of co-workers' styles can help in managing a variety of organizational interactions such as negotiation.

Negotiation is one form of organizational behavior that seems particularly influenced by participants' levels of empathy and perspective-taking but in different ways. Perspective-takers are seen gaining an edge on their partners by providing insight into the other party, thus improving the appeal of their arguments and offers (Ku et al., 2015). In addition, when perspective-taking is used to determine the lower bounds of acceptability to the other party it can offset the anchor effect and distributive advantage the other party gains in making the first offer (Galinksy & Mussweiler, 2001). On the other hand, the emotional reactions evoked through empathy, such as sympathy, are

seen as diminishing the negotiator's position (Ku et al., 2015). Another set of studies found that negotiations that involved a perspective-taker resulted in greater success than those involving empathy (the study actually measured empathic concern using the Davis scale) (Galinsky, Maddux, Gilin, & White, 2008). Galinsky et al. concluded that "understanding the interest and motives of opponents in competitive decision-making interactions appears more valuable than connecting with them emotionally" (p. 383). But, in one of their studies, sellers were most satisfied when they dealt with an empathic buyer, leading the researchers to suggest that empathy could be helpful in building interpersonal capital that would benefit future negotiations. In addition, empathy was seen as being valuable in certain types of negotiation, such as those that are emotionally charged.

Mnookin, Peppet, and Tulumello (1996, 2000) studied empathy's impact on negotiation as it related to assertiveness. Empathy and assertiveness are often viewed as competing approaches to negotiation. For example, highly assertive negotiators would use competitive styles while highly empathic negotiators would be accommodative (Mnookin et al., 1996, 2000). Mnookin et al. argued that the strongest negotiators are strong in both empathy and assertiveness. Such a combination involves a negotiator engaging in listening and demonstrating a nonjudgmental understanding of the other's needs, interests, and views without a statement of agreement but with an expectation for reciprocation from the other when the negotiator asserts her or his own needs, interests, and views. Social decentering allows a negotiator to appreciate the needs, interests, and emotions of the other party while analyzing the appropriateness and effectiveness of various strategies. A strong application of social decentering helps negotiators separate their own thoughts and feelings (use of self) from those of the other party (use of specific-other or RSSD). Such awareness helps in selecting strategies that reflect an understanding and appreciation of the other negotiator's stand. Such awareness also involves recognizing how one's own level of unrelenting assertiveness is counterproductive to negotiation. And, as Mnookin et al. (2000) contend about empathy and assertiveness, social decentering enhances negotiation when both parties skillfully engage in it.

External communication in organizations deals with employees' interactions with customers and clients. Empathy is seen as having a positive influence on customers. But the studies tend to focus on customer perception of empathy without regard for whether the employee is actually empathic. In other words, customers feel happier when they perceive positive, confirming behaviors from people like the sales staff or company representatives. For example, Weißhaar and Huber (2016) operationalized empathy as a multidimensional construct and had 215 customers of a German

consulting firm complete questionnaires assessing the perception of salespeople's perspective-taking and emotional concern. Perception of perspective-taking had a strong positive relationship to customers' trust and commitment to the salesperson, and to a lesser degree, the perception of emotional concern. One study that directly assessed employees' empathy was conducted by Wieseke, Geigenmüller, and Kraus (2012). Not only did they assess employee empathy, they also assessed customers' empathy. Agents from 93 German travel agencies and their customers completed a multidimensional measure of their empathy that included items regarding perspective-taking, empathic concern, and emotional contagion (feeling the same feelings as the other). Employees' empathy positively related to customers' reported satisfaction and loyalty. Employee empathy had an even stronger impact on customer satisfaction when customers themselves were higher in empathy. Interestingly, customers' emotional empathy sustained their loyalty even when satisfaction fell. The authors argue that the more empathic customers appear to be more sensitive to frontline employees' emotions, and thus more inclined to forgive dissatisfying service encounters. Wieseke et al. suggested that employers should "hire service employees capable of sensing customer expectations" as well as "offering opportunities for frontline employees to learn and develop their abilities to sense customer thoughts and feelings" (p. 326).

But there is a toll taken on frontline employees for being other-centered. Varca (2009) found that the more service personnel at a call center engaged in emotional empathy with callers, the more they experienced stress and role conflict. The conflict was caused by their effort to form an emotional attachment with the customer while at the same time having little authority to meet the customer's demands, leading to such service personnel responses as, "I feel as frustrated as you do, but there isn't anything I can do about it." Such a situation provides one explanation for high employee turnover at call centers and why the frontline employees you reach at a call center might seem detached – it's their way of reducing role conflict. Varca suggested that call centers that want their employees to be other-centered need flexible policies that include giving more authority to the frontline employees.

Despite creating possible role conflicts, service companies would do well to seek employees with strong affective and cognitive social decentering skills. Social decentering training could include an awareness of their use of generalized-other in understanding and responding to customers and the need to develop more RSSD with ongoing customers and clients. Such skill development is inherent in sales approaches that emphasize an other-orientation, such as personal selling, relationship selling, and adaptive selling. Sales performance, loyalty, and satisfaction benefits from a sales staff

who are able to gain enough information about customers to effectively apply social decentering in the development of sales strategies.

Social decentering and RSSD can take their toll on managers who become burned out from engaging in a significant amount of emotional work with subordinates. As discussed earlier, emotional work is inherent in some professions such as counselors, social workers, and nurses. But such burnout can also happen wherever a close relationship exists between an employee and a customer or client such as financial advisors (Miller & Koesten, 2008) and real estate agents (Snyder, Claffey, & Cistulli, 2011). Actually, any manager whose role involves significant interpersonal contact with subordinates can experience burnout (Cordes & Daugherty, 1993). Managers with strong social decentering and RSSD are susceptible to emotional exhaustion and depersonalization that result from frequent intense discussions with subordinates about the subordinates' personal difficulties. The impact would be most likely to occur in situations in which managers experience the emotional burdens of multiple subordinates over extended periods of time. Miller and Koesten (2008) noted that their sample of financial planners managed emotional attachment by being able to "feel with" their clients, while also "feeling for," and thus create "detached concern." In other words, being able to engage in social decentering and RSSD but also being able to disengage, perhaps moving from affective responses of empathy to more cognitive response of analysis and perspective-taking.

A subtle but important feature of Wieseke et al.'s (2012) study was the inclusion of the customers' level of other-orientation. The results of my studies reported in the relationship and marriage chapters confirmed the transactional nature of social decentering in relationships such that both parties affect and are affected by each other's social decentering and RSSD. Both partners' levels of social decentering and RSSD interact with the other, whether the relationship is between employees and customers, managers and subordinates, or co-workers. A subordinate who is strong in social decentering interacting with a manager who is strong in social decentering will produce more positive outcomes than a subordinate and manager who don't understand or appreciate each other's dispositions.

Parker et al. (2008) provide an extended examination of the factors that inhibit perspective-taking in organizations and how perspective-taking can be enhanced. As with social decentering, one of the most critical factors identified was the need to be motivated to perspective-take or at least to try:

> A person who is highly motivated to understand where another is coming from will try harder, will engage in a wider range of cognitive, emotional, behavioral

> strategies, and will persist longer in order to learn the perspective of another. (p. 171)

Parker et al. point out that in some instances professional roles don't seem to have perspective-taking as necessary or valued. Organizations would do well to expand the expectations for all personnel to more consciously engage in social decentering – take time to think about the dispositions of co-workers, managers, subordinates, customers, clients, and suppliers. Motivation stems partially from the belief that there is value in understanding others. The degree to which another person in the organization is important, either on a personal level (liking and friendship) or professional level (power and ability to reward), affects the degree to which people are motivated to engage in social decentering with co-workers. Organizations that foster a culture of considering other's dispositions and adapting accordingly are likely to be more productive and enhance satisfaction with the work environment thus reducing stress and turnover.

Intercultural Interactions

Effectively engaging in social decentering is easiest when the two interacting individuals are very similar and most difficult when the two individuals are very different. When someone is different, the use of self is less relevant (though not altogether) and the use of generalized-others can become more valuable particularly if people have built meaningful group schemas that apply to the other person. Everyone is different from everyone else to some degree but there are degrees of difference. At one end are differences in sex and age, and at the other end are differences in religion, ethnicity, and culture. Each difference limits the ability to effectively socially decenter until we acquire sufficient information. The ability to socially decenter will be minimally affected by the age difference of a 40-year-old person talking to a 46-year-old person. But a 20-year-old man from Iowa talking to an 80-year-old woman from Malaysia would only be able to socially decenter in very broad terms – a young man to an older woman. The first step in socially decentering with diverse others is mindfulness of the differences. The second step is considering the effect those differences have on our perceptions and behaviors toward the other person. We need to realize when our perception is distorted or biased and thus undermining our ability to effectively engage in social decentering. The third step is to begin applying social decentering toward understanding how the dispositions of the other person are different from our own. We quickly recognize when someone is a different sex than us, but do we really think about how that other person's life is affected because of their sex. Do men understand the demeaning way women are often treated by men and how that

affects the women? Is a woman, who believes all men are misogynistic, able to set that view aside in her initial interaction with a man? Regardless of the level of difference, social decentering is an important tool to use in appreciating, learning, understanding, and adapting to those differences. Social decentering is only one skill that individuals need when engage in intercultural interactions. Scholars have identified various sets of skills needed to successfully manage intercultural interactions, that are often labeled intercultural competence or intercultural communication competence. One of the more consistently identified skills that contributes to intercultural competence is empathy (see review by Matveev, 2017). But cultural differences and a lack of information often make it difficult to empathize.

Intercultural interactions are among our most challenging interactions due to potential differences in language, nonverbal cues, values, beliefs, attitudes, customs, and world views. In intracultural conversations there is a rather large level of intrinsically shared information that makes the interaction much more manageable. But in intercultural conversations there can be a significant amount that is unknown about the other which hampers the interaction and social decentering.

Social decentering in initial intercultural interactions generally relies heavily on the use of generalized-others method of analysis. We draw upon whatever preexisting classifications and stereotypes we have of people based on country of origin. For some people only one category might be used – foreigners. In other words, these people categorize anyone not from their country as alien or foreign. Such an encompassing category is an ineffective basis for social decentering since it produces little understanding or ability to predict. Some people have a multitude of categories, even to the point of having several categories in which to place people from the same country. For example, rather than just a category of Iraqi, an individual might instead categorize Iraqis as Sunni, Shite, and non-Muslim with an appreciation for the beliefs and values of each group. But as discussed in Chapter 1, having many categories can be unwieldy and defeat the purpose of creating easily accessible groupings of information. Our cultural categories are likely to be limited to those cultures with which we have the most experience or exposure.

The cultural categories we create and access in the use of generalized-other analysis provide initial information that we can use to understand and predict someone we have just meet from a given culture. Gudykunst (1995) observed that:

> The categories in which we place strangers also provide us with implicit predictions of their behaviors. When we categorize strangers, our stereotypes of the groups in which we categorize them are activated. Our stereotypes provide predictions of

> strangers' behavior and our interactions will appear to have rhythm if strangers conform to our stereotypes. (p. 22)

For Gudykunst, use of generalized-other allows us to coordinate our initial conversation to the degree that our expectations align with the actual behavior of the other person. But no one totally fits a stereotype, so it becomes important to recognize and adapt to differences between categorical expectations and the observed behaviors of the other person. Gudykunst (1993) identified the need to be mindful as an important element toward intercultural communication effectiveness. Three factors identified by Langer (1989) that contribute to mindfulness were incorporated into Gudykunst's (1998) description of a plan for intercultural adjustment training. These factors are imbedded in successful intercultural social decentering. The first factor is a need to create new categories; categories that are more specific to each culture rather than relying on broad categories. The second factor is openness to new information, that is used in creating and refining the new categories. Inherent in this factor is a motivation to learn, as well as awareness and sensitivity to cultural differences. The third factor is recognition that there is more than one perspective, which Langer observed, gives more choices for responding. Essentially, Langer reminds us that the way we see the world is not the same as the way other people see the world and that we need to be sensitive to that in how we think, what we say, and what we do. Such awareness of other perspectives and consideration of multiple responses are intrinsic elements of the social decentering process. Social decentering is again the tool that, in concert with mindfulness, allows us to recognize different perspectives, be open to information we learn about others' perceptions, and create new categories that facilitate successful intercultural interactions. Over time, we gain idiosyncratic information about the other that allows us to develop RSSD that incorporates relevant cultural knowledge and cultural nuances.

The social decentering scale was designed to assess individuals' tendencies to form and use categories as part of the use of generalized-others analysis. Four of the 12 items that constitute the use of generalized-other subscale specifically assess people's intercultural sensitivity:

1. *I have wondered what people in some foreign countries think about various world problems.*
2. *I take into consideration both the situation and a person's cultural and ethnic background when I'm trying to understand the behavior of someone I don't know very well.*
3. *I can imagine how some of my attitudes, beliefs, and values might be different than they are if I had been raised in a different country's culture.*

4. *I know some of the values, attitudes, and thoughts associated with different cultural and ethnic groups.*

Interacting with those who are different from us creates uncertainty, stress, and anxiety. Gudykunst and Hammer (1988) extended uncertainty reduction theory to initial intergroup/intercultural interactions and added anxiety as a factor affecting people's thoughts and behaviors. Gudykunst (1988) recognized that people feel anxious about interacting with others whose culture differs from their own. Gudykunst's (1993, 1995, 2005) theory sought to identify the aspects of intercultural interactions that affect and are affected by uncertainty and anxiety. The aspects of his model most related to social decentering include ability to empathize, ability to adapt communication, knowledge of similarities and differences, and the ability to create new categories into which we place groups of people. Possessing such attributes reduces uncertainty and anxiety which in turn results in more effective intercultural communication.

On the other hand, Gudykunst (1993) claimed that when we exceed our maximum threshold for uncertainty or anxiety, we are unable to communicate effectively. The combination of anxiety and ineffective communication results in an inability to accurately interpret or predict the other person through social decentering. Use of self proves ineffective because of the significant differences between decenterers and their intercultural partners. The maximum threshold reflects a circumstance in which we have no specific-others or generalized-others to provide a foundation for interpreting or predicting.

Social decentering heightens our awareness that our interactions with someone from another culture differs from what we are used to and from what we expect. Such awareness results in increased stress and anxiety because of an inability to effectively understand and predict the behavior of the other person. Thus, social decentering contributes to the stress experienced by sojourners. On the other hand, travelers low in social decentering are likely to be somewhat oblivious to the cultural differences and therefore inclined to feel less stress. In a study of 644 international students attending Iowa State University conducted by myself and my colleague, Judith Bunyi (Redmond & Bunyi, 1993), the effect of social decentering was confirmed by a positive correlation between the students' level of social decentering and their reported stress. Respondents were consolidated by countries and regions to produce 14 similar size samples. Analysis of variance of the 14 samples indicated no significant differences in their average social decentering scores. But significant differences were found among the countries/regions in students' ability to adapt, socially integrate, and communicate effectively. One possible explanation for the stress can be found by examining the level

of difference between countries of origin and the host country. The similarity of social decentering scores among international students indicates that social decentering is skill that occurs across cultures unlike more culture-dependent skills such as communicating effectively. Some skills like language acquisition and knowledge of the host culture limit intercultural competence to interactions within specific cultures. On the other hand, social decentering is a transcultural quality in which people recognize similarities and differences in each culture they encounter and have the capabilities to observe, learn, analyze, and understand the people with whom they interact in each culture.

Geert Hofstede (1980, 1983, 1997, 2001) identified four central values that he found varied among cultures: power distance, uncertainty avoidance, individualism/ collectivism, and masculinity/femininity. In a follow-up analysis of the data from the previous study, I conducted regression analyses for students whose cultural values were closest to the US values; and an analysis for students whose values were furthest away (Redmond, 2000b). Social decentering significantly contributed to the prediction of greater stress associated with differences and similarities for each of the four cultural values for both those close and far away in value. The following beta weights for social decentering for students coming from cultures most similar to the United States are listed in order of value: 0.31 – uncertainty avoidance, 0.23 –masculine/ feminine, 0.15 – power, and 0.14 – individualism/collectivism. Beta weights for students least similar to the United States were, in order of value: 0.30 – individualism/collectivism, 0.26 – power, 0.22 – masculinity/femininity, and 0.12 – uncertainty avoidance. For students coming from cultures high in uncertainty avoidance similar to the United States, the issue of similarity is probably less consequential than the value itself. Possessing the cultural value of intolerance for ambiguity is likely to produce stress regardless of the host country's value. Social decentering is likely to exacerbate the stress for those with intolerance for ambiguity by increasing the respondents' awareness of that ambiguity. Sojourners can expect that certain cultural differences between themselves and theirs host countries along with their engagement in social decentering will compound their initial stress.

Social decentering was not found to directly relate to the ability to cope with stress as they related to differences in the four values. One reason for this might be that social decentering did not relate to the countries of origin and thus did not differ relative to other communication competence differences between the native culture and the United States, as for example, language did. Communication effectiveness, ability to adapt, and the ability to integrate into the social network of the United States positively contributed to a student's ability to cope with stress. Social decentering contributes to these three intercultural communication competencies and thus has an indirect impact

on handling stress. For example, social decentering provides an understanding of host culture members that enhances the ability to adapt. Social decentering also helps sojourners predict a host member's reactions to various behaviors and thus improve strategic choices. For example, through social decentering, a male student from Spain might forego his cultural norm of kissing females on the cheeks as a greeting and instead offer to shake hands when meeting a female student from the United States, predicting that she would back away if he tried to kiss her on the cheeks. Such awareness improves the likelihood of successfully integrating into the host culture's social network.

Another term introduced to reflect intercultural other-orientation is cultural empathy, which Kim (1988) conceptualizes as the ability to be flexible in ambiguous and unfamiliar situations. Two dimensions of cultural empathy that were identified by Cui and Van Den Berg (1991) are empathizing with cultural norms and awareness of cultural differences. They found cultural empathy contributed to the intercultural effectiveness of US business people working in China. Unfortunately, the conceptualization and measurement of cultural empathy is inconsistent. For example, one measure of cultural empathy is the Multicultural Personality Questionnaire (Van der Zee & Van Oudenhoven, 2001), that appears to be a general measure of empathy that does not include cultural contexts. Part of its validation consisted of comparing the respondents' self-reports to reports about them from a partner, close friend, or family member. This measure has been used by other researchers as well (see review by Arasaratnam, 2014). The use of *cultural* to describe empathy is misleading and by default implies that there isn't anything unique about empathizing with people from the same or different cultures. In contrast, the measure of social decentering includes use of generalized-others analysis, that assesses individuals' ability to draw on their knowledge of other cultures in the process of understanding and predicting diverse others.

The term cultural empathy is also used to describe a special form of empathy utilized by counselors when dealing with clients from different cultures (Ridley & Lingle, 1996; Ridley & Udipi, 2002). Ridley and Lingle defined cultural empathy as "the learned ability of counselors to accurately gain an understanding of the self-experience of clients from other cultures" (p. 32) and to communicate that understanding with an attitude of concern. Several of the characteristics they associate with cultural empathy are also characteristic of social decentering, such as being multidimensional, being an interpersonal process, the similarity between counselors and clients helping to establish understanding, and the ability to learn the skill. The inclusion of communicating understanding as part of cultural empathy differentiates it

from social decentering. As discussed earlier, social decentering and empathy are valuable tools for effective counseling. But contrary to Ridley and Lingle, I would argue that just as social decenterers might choose not to disclose their understanding or predictions, culturally empathic counselors might choose not to reveal their understanding or predictions when they think such revelation would undermine the relationship or therapy.

Ridley and Lingle (1996) identify counselors' tendency "to impose their cultural values onto their clients" (p. 38) as a significant problem in multicultural counseling. This problem is similar to relying on the use of self analysis for making sense of clients' cultural dispositions. Such an error comes from the incomplete application of social decentering. Use of self can be an effective tool in intercultural interactions by accentuating how the decenterer's thoughts and feelings differ from those of the targets, leading to a keener understanding and appreciation of other people's cultural experiences. But use of self without attending to how the self differs from others undermines intercultural communication. To effectively socially decenter in intercultural interactions, egocentrism (use of self while ignoring differences) and ethnocentrism (imposing our cultural values on others) must be avoided.

Building off Ridley and Lingle's notion of cultural empathy as it applies to counseling, Wang, Davidson, Yakushko, Savoy, Tan, and Bleier (2003) developed the concept and measure of ethnocultural empathy. Ethnocultural empathy is conceptualized as "empathy directed toward people from racial and ethnic cultural groups who are different from one's own ethnocultural group" (p. 221). The concept was initially operationalized as having three components, but four emerged from their data analysis: intellectual empathy (understanding racially or ethnically differences), empathic emotions (attention to and feel the other's emotional condition), communicative empathy (expressing empathic thoughts and feelings), and empathic awareness (social and media treatment of racial and ethnic groups). As operationalized, the scale appears to have limited application to interactions between people from different countries, since its focus is on intracultural interactions that cross race and ethnicity. Many of the scale items revolve around attitudes on racism, hate crimes, discrimination, etc. But such awareness is also pertinent to intercultural interactions, for which there is a need to be sensitive to cultural biases held against various ethnic groups within other cultures.

The ethnocultural empathy scale does highlight an important application of social decentering to interactions among diverse citizens in the same country who differ in terms of race and ethnicity, to which I would add, differ from each other in religion, sex, sexual orientation, mental and physical abilities, and even social economic status.

Each of these reflect groups within a given culture for which there might exist biases, prejudice, discrimination, conflict, and social mores. The ethnocultural empathy scale brings attention to these intracultural contexts and defines ethnocultural empathic individuals as those who are aware of how their shared culture treats people differently depending upon group identification. The definition of social decentering ends with the phrase "within a given situation." Given situation is meant to reflect the specific circumstances that currently surround the person with whom we are socially decentering. But those circumstances go beyond what is occurring at a given moment and include the broader social-cultural context in which the other person lives. For social decentering to be effective, a white university student from London would need to consider the social climate and prejudices that a black student from Sweden has experienced. A consideration of the ethnocultural influences on each person is important if we are to truly understand their thoughts and share their feelings. In some ways, we create a category or stereotype of a particular group of people that is an amalgam of information about how members of that category are treated by the culture and society. As with any category, individual members of these ethnocultural groups do not all share the same experiences and for that reason, it is particularly important for individuals to listen and acquire information that allows them to develop and access the use of specific-other level of social decentering analysis and RSSD. In their discussion of cultural empathy in counseling, Ridley and Lingle (1996) emphasize the need for counselors to explore a particular client's cultural group experience, particularly in terms of how it deviates from the normative.

Stereotypes and perceptions of outgroup members (other cultures) are often tainted with bias and prejudice that can then undermine effective communication (Beebe, Beebe, & Redmond, 2017). While contact leads to learning about outgroup members which in turn can reduce prejudice, Pettigrew (2008) observed that "empathy and perspective-taking are far more important" (p. 190). He noted that contact facilitated empathy and perspective-taking with the outgroup. Empathy as an affective process was seen as having a stronger effect on reducing prejudice than did the cognitive process associated with perspective-taking. Pettigrew and Tropp (2008) conducted a meta-analysis of extant research on prejudice, empathy, and anxiety that indicated that: anxiety had a negative mediating effect between contact and prejudice; empathy had a positive effect; and empathy and anxiety were negatively related. These findings led them to postulate that "initial anxiety must first be reduced with intergroup contact before increased empathy, perspective-taking, and knowledge of the outgroup can effectively contribute to prejudice reduction" (p. 929). As applied to social decentering this means that when people are anxious about interacting with someone from another

culture that anxiety is going to inhibit their ability to socially decenter. Positive intergroup contact can reduce that anxiety (Pettigrew, Tropp, Wanger, & Chirst, 2011), which leads to increased information exchange and a reduction in the emotions that were blocking socially decentering.

Intercultural business interactions combine the impact of the organizational factors discussed earlier with issues of cultural differences. The earlier discussion of managers, employees, and organizations has a definitive western bent to it. While there is similarity in the roles and expectations of managers across cultures, there are also differences. For example, employers in France create very family-like relationships with employees, and subordinates in Saudi Arabia tend to avoid eye contact with superiors (Blacharski, 2008). Matveev and Nelson (2004) described the benefits of empathy in multicultural business teams:

> A culturally empathetic team member has the capacity to behave as though he or she understands the world as team members from other cultures do, has a spirit of inquiry about other cultures and the communication patterns in these cultures, an appreciation for a variety of working styles, and an ability to view the ways things are done in other cultures not as bad but simply as different. (p. 258)

The broad description of cultural empathy imbedded in the above list is a better description of what occurs through social decentering than empathy. Social decentering provides a foundation for understanding, requires motivation, involves examining and comparing general categories of people including cultures and working styles, and the ability to learn by recognizing similarities and differences in cultures between oneself and others.

Matveev and Nelson (2004) hypothesized that coming from a more collectivistic culture, Russian managers would have higher cultural empathy than American managers coming from an individualistic culture, but the results of their study found no significant difference. They argued that the American managers were driven to perform and achieve individual growth that motivated them to be culturally empathic. This means individuals are likely to engage in social decentering when their individual motivations exceed the cultural value of self-orientation. Social decentering is an effective tool for accomplishing personal goals, and in that way, being other-oriented allows individuals to accomplish self-goals, which means it is of value in both collectivistic and individualistic cultures, albeit, for different reasons.

Other Contexts

While the focus of this text has been on social decentering in interpersonal interactions, it can also be applied in less interactive contexts. For example, in writing this book I have tried to consider who will be reading it and what they might most want to know. I've also tried to consider how they will react to what I have written. I've relied upon my use of generalized-other in making that assessment as well as use of self. Use of self is sometimes problematic though because one's ego and face come into play. I often experience negative reactions to re-reading something that I wrote a year earlier when I now find that I originally failed to notice its errors and weaknesses.

Most media involves some degree of audience analysis, which is a type of other-orientation that involves considering the dispositions of some general audience rather than a particular individual. But in today's world of technology, more and more websites collect information about each user and then target ads and other information to that information; essentially, computers are being programmed to socially decenter, though inclusion of an emotional component is still a work in progress. I remember in the 1980s that there was a computer program that acted as a counselor. Essentially, the program simply sent back what the user typed and added a question mark or displayed a message "Tell me more," or "How do you feel about that?" Obviously, the computer had no understanding or empathy but used counseling catchphrases to get people to explore themselves. This example illustrates the reason it is important to convey the depth of your understanding that is developed when you considered another person's dispositions and given situation.

Being audience-centered is a notion shared by public speakers, authors, producers, marketers, and entrepreneurs. Considering the dispositions of the targets can facilitate accomplishing one's goals with live or mediated audiences, readers, or consumers. The process of social decentering applies here because people collect and analyze information that allows them to evaluate and predict the effectiveness of the messages or products they create. Marketing surveys are attempts to collect information about a target audience to create messages that can be adapted to that audience and thus be most effective. You have probably watched a TV commercial that you thought was senseless and wondered why it was ever created. In those instances, the creators either failed to understand you and predict your reaction, or more likely, you were not their target audience. But if your friends agree with you, that the commercial was senseless, that still might not mean the commercial failed since you and your friends are similar and perhaps none of you are the target audience. For example, in the United States, TV shows and commercials target 18- to 34-year-old viewers the most, which means in the

US, that if you and your friends are over 40, the ad probably wasn't aimed at you. Prandelli, Pasquini, and Verona (2016) found that having graduate management students consider the perspective of a potential user resulted in enhancing their creativity in considering and addressing the user's needs while applying their own expertise. The experimenters activated the students' social decentering efforts using the information provided about the user/consumer to evaluate and predict the user's preferences thus enhancing their entrepreneurial success.

Audience adaptation is often a core principle taught in public speaking textbooks. Its role was explained by my colleague, Denise Vrchota and myself (2007), "Adaptation involves using your understanding of the audience and the situation to select strategies tailored to the audience's needs and interests" (p. 11). Funny how this definition reflects my principles of social decentering, isn't it? Even the questions we suggest readers answer are similar to the questions asked when social decentering, for example, "If I were sitting in this audience, what would I want to hear?" (use of self), "How is this audience different from me?" (use of self and use of specific-other), and "What does *this* audience want?" Interactions with audiences are somewhat akin to intercultural encounters in that they vary from speaking with audiences about whom very little information is known, to speaking to audiences with whom the speaker has an ongoing relationship and in-depth information.

For authors, social decentering not only allows them to consider their audience, it serves as a method of creating and expanding characters. One piece of advice from children's literature editor Mary Kole (2012) to authors reflects the use of self as a way to write more effectively: "When you know the teen experience and can place yourself in your target readers' experience, you're that much more likely to write a book that resonates with them on a deeper, thematic level." Authors of young adult fiction draw from their memories of their own teenage experiences, listen in to conversations among teens while riding the bus, and interact with teenage relatives as a foundation for adapting their writing to their readers (*The Guardian*, 2015). Such practices reflect authors' efforts to gain information either from observation and memory, and by imagining life as a teenager, and then writing in a way that reflects that appreciation and understanding. Such authors utilize the use of self in both recalling and imagining their thoughts and feelings, extrapolate from their knowledge and experiences with specific teenagers (use of specific-others), and significantly employ use of generalized-others by creating categories of teenagers on which to build and develop characters. Strength in social decentering allows authors to create relatable and believable characters. Failure to effectively socially decenter has probably undermined the success of many an author.

Any communication that is directed to a specific person or target audience can be enhanced through the use of social decentering. Besides books, speeches, and advertising, social decentering plays a significant role in today's world of electronic communication. For example, knowledge of another person allows us to "encrypt" text messages with references, abbreviations, or idioms we know the other person will understand. A number of studies have examined the impact of social media on empathy but with mixed results. Concerns have been raised about the negative impact of the Internet on people's social skills with some studies finding a negative impact on face-to-face interactions and empathy among those spending considerable time online including social media and gaming. But a longitudinal study of 942 Dutch adolescents (10–14 years of age) found that the initial reports of social network use were positively related to higher cognitive and affective empathy a year later (Vossen & Valkenburg, 2016). The researchers concluded that frequent use of social media improved adolescents' "ability to share and understand the feelings of others over time" (p. 123) by providing them opportunities to practice.

Another survey with over 1,000 respondents between the ages of 18 and 30 asked about their "time behind the screen" use (TV, computer, and phone) and used the basic empathy scale to assess their cognitive empathy (essentially thoughts about other people's feelings) and affective empathy (feeling or not feeling what others feel) (Carrier, Spradlin, Bunce, & Rosen, 2015). Other assessments included virtual cognitive and affective empathy (the basic empathy scale revised to apply to an online context), and social support. No significant correlation was found between time online and either cognitive or affective empathy for men. For women, no significant relationship was found for time online and affective empathy, but a small negative relationship was found with cognitive empathy ($r = -0.09$). The kind of online activity appears to mediate the relationship between time online and empathy. Video gaming significantly reduced cognitive and affective empathy for women and cognitive empathy for men. Regression analysis indicated that the use of a computer for such activities as e-mailing and instant messaging lead to more face-to-face communication and that lead to improved affective and cognitive empathy. But such computer use did not directly affect empathy. The results of the study led the authors to speculate that social connections might result in more arranged face-to-face meetings or increased the chances of seeing the person off-line, which then increases the opportunities to hone empathy skills. Carrier et al. found that empathy significantly correlated with virtual empathy, but virtual empathy was not as strong. Cognitive empathy and affective empathy strongly related to social support ($r = 0.37$ and 0.24, respectively). Virtual cognitive empathy and affective empathy positively related to social support, but to a

much smaller degree than general empathy (r = 0.15 and 0.10, respectively). The overall implication of Carrier et al.'s study is that people who are empathic maintain their empathy regardless of how much time they are online. While a high amount of video gaming was related to less empathy, those inclined to spend hours upon hours gaming are generally less empathic than the general population and their video gaming becomes a replacement for social engagement.

We can expect that the findings from Carrier et al.'s study applies equally well to social decentering. People who are strong in social decentering are likely to maintain that strength regardless of how much time they spend online. The relationship between social decentering and online activity is twofold: first, the degree to which individuals apply social decentering while online, and second, the degree to which online activity informs or influences social decentering. Imagine you are checking your Facebook page and see a post and picture from a close friend at a party looking sad and uncomfortable as several people crowd around trying to get in the picture. Because of your RSSD with your friend, you know that must have been an awkward moment since your friend dislikes being crowded and touched. So, you send your friend a personal message expressing your understanding and concern. In this instance, social decentering that exists outside the online universe is applied to understanding another's online communication. On the other hand, the photo could be an indication that your friend is trying to be more social and that might prompt you to confirm that with your friend. As a result, you add to your knowledge of your friend and thus improve future application of RSSD. This example illustrates how social decentering can be used in social media to both understand and predict the communication of others and as a source of information to help develop further social decentering.

Our online experiences fall into two broad categories: passive and interactive. Passive experiences are those where we simply observe or consume without any direct interaction with the source. Watching an online video reflects this passive experience and responding to text messages and posting likes or commenting on someone's Facebook post represent interactive experiences. Social decentering plays a different role in each. For the passive experience, social decentering is primarily activated to provide understanding. You might receive a text message from your boss and use social decentering in considering the meaning and intent without replying. When engaging interactively in social media, one of our prime concerns is the maintenance of our relationships. In these social-mediated instances, the application of social decentering is utilized as with any interpersonal relationship. Social-mediated experiences can also include reacting to strangers about whom we have limited information. We can engage

in social decentering with these individuals, but are limited to what we observe, imagine, relate to, or use from our understanding of people in general.

Remember that the first thing that has to happen for social decentering to occur is for it to be triggered. Our detachment with people online is likely to reduce the likelihood of engaging in social decentering. If you have a lot of Facebook friends, you are likely to skim quickly through their posts and pictures with little in-depth analysis. A posting by a stranger is unlikely to stimulate social decentering if you perceive little consequence. The level of relational intimacy with the sender/poster, the relevance of what is sent/posted, and the importance you associate with a given online message are factors that mediate the decision to socially decenter. Once trigged, we attend to the information at hand, in memory, and imagined. A unique aspect of mediated communication is that we have records such as old text messages or Facebook posts that can be reviewed. For example, you could scan pictures on your friend's Facebook page for confirmation of your belief that your friend is uncomfortable in crowded social situations and thus feel more confident about your social decentering and RSSD. The use of any of the three social decentering methods for analyzing and adapting to another person in the social media network is dependent on how much information is available about the person and the person's situation. If we know a lot about the person we encounter on social media, then we are apt to apply use of specific-other or RSSD. If we only know a little about the person who texted or posted, we are likely to apply use of generalized-other to consider the thoughts and feelings associated with the message/ post – what do most people mean by such a post? The more we know about the situation, the more effectively we can apply use of self for analysis. Reading a detailed story online about the police mistakenly raiding the wrong address and arresting the resident provides enough information for you to apply the use of self analysis as your recall any similar incident happening to you or imagining it happening to you and how you might react. Next comes your internal response, the thoughts, and feelings that are aroused as a result of what we observe on social media. In instances where we are simply a passive observer, the accuracy of our understanding and emotional responses is fairly unimportant. When we engage in interactive social media experiences, usually within the context of ongoing relationships, social decentering plays a more critical role in helping us consider the person and their situation as we develop our response. Another advantage of some mediated interactions is the ability to take time to consider the person and the situation before responding. I've had to remind myself over the years when I'm irritated by someone's email not to immediately send a response, but instead take time to consider how the other person will react to the various messages I might send. My response after waiting a day is almost always a lot more constructive. Which

brings us to the last part of social decentering – to act. Sometimes, my analysis of the email and person who sent it results in a decision to do nothing. Of course, that makes it appear to outsiders that I did not engage in social decentering, but in reality, social decentering led me to conclude that taking no action was smart thing to do. As introduced in Chapter 1, social decentering is not a personality trait and not an unconscious reaction, but is social cognition. Such a distinction is not meant to diminish or deny the occurrence of truly empathic emotional responses or altruistic acts. It is meant to clearly identify the cognitive process presented in this book by which humans thoughtfully consider the thoughts, feelings, and dispositions of other people and in so doing successfully navigate their social worlds.

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